



**SUNOSI PRIOR AUTHORIZATION FORM**  
**PATIENT INFORMATION**

Subscriber's ID Number		Subscriber's Group Number	
Patient's Name	Phone	Date of Birth	
Address	City	State	Zip Code

**PRESCRIBER INFORMATION**

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

**MEDICATION INFORMATION**

Requested Strength:	<input type="checkbox"/> 75mg	<input type="checkbox"/> 150mg	Quantity <u>per Month</u>
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Diagnosis:

**CLINICAL CRITERIA**

**MEDICATION HISTORY**

- Has the patient experienced therapeutic failure, contraindication, or intolerance to generic Modafinil?  
 Yes       No
- Has the patient experienced therapeutic failure, contraindication, or intolerance to generic Armodafinil?  
 Yes       No
- Has the patient experienced therapeutic failure, contraindication, or intolerance to a generic CNS stimulant (e.g. dextroamphetamine, methylphenidate)?  
 Yes       No
- Please provide any other medications previously tried and failed for the patient's diagnosis:  
 \_\_\_\_\_  
 \_\_\_\_\_

**OBSTRUCTIVE SLEEP APNEA**

If the patient has **obstructive sleep apnea**, please answer the following:

- Is the patient currently receiving and compliant with continuous positive airway pressure (CPAP)?  
 Yes       No
- Is the patient experiencing persistent daytime sleepiness despite adequate obstructive sleep apnea treatment?  
 Yes       No
- Have alternative causes of daytime sleepiness been excluded?  
 Yes       No
- Please provide the following from the patient's **diagnostic** polysomnography:  
 Apnea/hypopnea index (AHI) in events/hour: \_\_\_\_\_

5. Is the patient experiencing any of the following symptoms? Please select **ALL** that apply:

- Coronary artery disease     Unrefreshing sleep     Mood disorder     Insomnia  
 Congestive heart failure     Cognitive dysfunction     Atrial fibrillation     Fatigue  
 Type 2 diabetes mellitus     Daytime sleepiness     Hypertension     Stroke  
 Unintentional sleep episodes during wakefulness     Waking up holding breath, gasping, or choking  
 Bed partner describes loud snoring, breathing interruptions or both

### **NARCOLEPSY**

If the patient has **narcolepsy**, please answer the following:

1. Please provide baseline data of the following:

Excessive daytime sleepiness (EDS) via the Epworth Sleepiness Scale (ESS): \_\_\_\_\_

Maintenance of Wakefulness Test (MWT): \_\_\_\_\_

2. Please provide the following results of the patient's multiple sleep latency test (MSLT):

Mean sleep latency (in minutes): \_\_\_\_\_

Number of sleep-onset rapid eye movement periods (SOREMPs): \_\_\_\_\_

3. Please provide the following from the patient's diagnostic polysomnography:

Number of sleep-onset rapid eye movement periods (SOREMPs): \_\_\_\_\_

4. If the patient has hypocretin-1 deficiency, please provide the following:

Cerebrospinal fluid hypocretin-1 level (in pg/mL): \_\_\_\_\_

Cerebrospinal fluid hypocretin-1 laboratory reference range: \_\_\_\_\_

5. Does the patient have a diagnosis of cataplexy?

- Yes     No

a. If **YES**: please provide the patient's baseline number of cataplexy episodes: \_\_\_\_\_

### **REAUTHORIZATION**

Is this a request for reauthorization?     Yes     No

If **YES**, please select **ALL** that apply:

- The patient has experienced improvement in daytime sleepiness  
 The patient has experienced improvement on the ESS\*\* or MWT\*\*\* compared to baseline

\*\*Epworth Sleepiness Scale

\*\*\*Maintenance of Wakefulness Test

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

## **INSTRUCTIONS FOR COMPLETING THIS FORM**

1. Submit a separate form for each medication.

2. Complete **ALL** information on the form.

**NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*

3. Please provide the physician address as it is required for physician notification.

4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**

Or mail the form to:    **Clinical Services,**

**120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222**